PART I INTAKE, SCREENING, AND ASSESSMENT FORM

A. Applicant Information

Date: _____

Region:_____ Case Manager:_____

Referral Date:_____ Referred by:_____

Name:_____ Social Security #:_____
First Middle Last

Client ID#: _____

Address:_____

City:_____ County: _____

State:_____ Zip:_____

Date of Birth: _____ Phone: ( )
Month Day Year

Gender: Female: ___ Male: ___ Height: _____ Weight: _____

Marital Status		
☐	Married	Spouse Name: _____
☐	Divorced	Age: _____
☐	Widowed	Social Security #: _____
☐	Single (never married)	
☐	Unknown	

Legal Status	
☐	1. Legally competent Adult
☐	2. Parent or relative is guardian or conservator Name: _____
☐	3. Non-relative is guardian or conservator Address: _____
	4. State or county is guardian or conservator City: _____ State: __ Zip: ____
	5. Other:_____ Phone: _____

U.S. Citizen or Legal Resident: ___Yes ___No County of Origin: _____

Race or Ethnic Background					
☐	White	☐	Black	☐	Hispanic
☐	Asian or Pacific Islander	☐	American Indian or Alaskan Native	☐	Other (Specify)

Clients Primary Language					
☐	1. English	For #2 or #3 — Can the client speak English:	☐	Yes	☐ No
☐	2. Spanish	Understand English?	☐	Yes	☐ No
☐	3. Other:				

Primary Means of Expressions					
☐	1. None	☐	2. Gestures	☐	3.Speaks
☐	4. Sign Language or Finger Spelling	☐	5. Communication Board or Device:	☐	6. Other:

What problems are you having right now that are causing you difficulty? (Ask): How long have you have these problems? What services are you receiving? (If no answer is given, state reason: e.g., unable to answer question.)_____

_____

_____

Client's Residence					
☐	Private Residence	☐	Residential Care	☐	Other: _____
Provider ID #:					

Is client homebound? ☐ Yes ☐ No

Employment? ☐ Yes ☐ No ☐ Full Time ☐ Part Time

Day Training or Supported Employment Provider ID#: _____

Income: Employment $ _____ Social Security $ _____ Other $ _____

Health Insurances: Check Appropriate Boxes	Year	Year	Year	
Medicare - PART A				Medicare #: _____
Medicare - PART B				Medicaid #: _____
Medicaid				Medicaid Application pending: ___Yes ___No
Veteran's Administration				Date of Application: _____
HMO				
Other Health Insurance (Specify)				
Don't Know				

Diagnostic Status

Primary Diagnosis:

☐	1. None	☐	8. Epilepsy or Seizures
☐	2. Autism	☐	9. Mental Retardation
☐	3. Blindness	☐	10. Physical health problems requiring medical care by licensed nurse or physician:
☐	4. Brain or Neurological Damage: Chronic Brain Syndrome	☐	11. Mental Illness (formal diagnosis; psychosis, schizophrenia, etc.
☐	5. Cerebral Palsy	☐	12. Situation mental health problem (formal diagnosis; depression, anxiety, fearfulness, mood disturbance)
☐	6. Chemical Dependency	☐	13. Other:
☐	7. Deafness	☐	14. Brain Injury

Additional Diagnosis Conditions:

☐	1. None	☐	8. Epilepsy or Seizures
☐	2. Autism	☐	9. Mental Retardation
☐	3. Blindness	☐	10. Physical health problems requiring medical care by licensed nurse or physician:
☐	4. Brain or Neurological Damage: Chronic Brain Syndrome	☐	11. Mental Illness (formal diagnosis; psychosis, schizophrenia, etc.
☐	5. Cerebral Palsy	☐	12. Situation mental health problem (formal diagnosis; depression, anxiety, fearfulness, mood disturbance)
☐	6. Chemical Dependency	☐	13. Other:
☐	7. Deafness	☐	14. Brain Injury

Functional Limitations/Needed Assistance

Level of Mental Retardation and/or Brain Injury (Mark One)

☐	1. Not Mentally Retarded	☐	4. Severe (IQ 20-35)	☐	7. Brain Injury
☐	2. Mild (IQ 51-70)	☐	5. Profound (IQ under 20)		
☐	3. Moderate (IQ 36-51)	☐	6. Unknown, Delayed, at Risk		

Environmental Assessments

Life and Safety Issues

Are you concerned about your safety in your home or neighborhood?	☐	Yes	☐	No

Please list any problems:

_____

_____

_____

PART II BRAIN INJURY WAIVER COMPREHENSIVE ASSESSMENT FORM

Mental Status Questionnaire (MSQ) Orientation-Memory-Concentration Test (Katzman 35.al., 1983)

(Write in answers to the questions. Do NOT try to score until after evaluation. Score 1 for each incorrect response up to the maximum errors for the item. In scoring, a " no" response is treated as incorrect.)

(Sample text for Support Coordinator) Now I'm going to read you a list of questions. These are questions that are often asked in interviews like this, and we are asking them the same way to everyone. Some may be easy and some may be difficult. Let's start with the current year.

Items	Applicant's Response	Maximum Errors	Score			Weigh t	Weighted Score		
			Year	Year	Year				
1. What year is it now?		1				x 4 =			
2. What month is it now?		1				x 3 =			

(Tell the client you are giving them a man's name and address to memorize. Note: This information will be used in question #6 below.)
PHRASE TO MEMORIZE: John Brown, 42 Market Street, Chicago
(Elicit 3 correct repetitions from the client, phrase by phrase or word by word, if necessary, before continuing.)

3. Without looking at a clock, about what time is it? (within 1 hour)								1					x 3 =						
4. Count backwards from 20 to 1. (Mark missed/out of order # in boxes)								1					x 2 =						
20	19	18	17	16	15	14	13	12	11	10	9	8	7	6	5	4	3	2	1

5. Say the months in reverse order. Hint: Start with month of Dec. (marked missed/out of order boxes)						Maximum Error 2	Year	Year	Year	x 3 =	Year	Year	Year
Dec.	Nov.	Oct.	Sept.	Aug.	July	June	May	April	March	Feb.	Jan.		

6. Ask the client to repeat the memory phrase. (Write the client's response on the line below to score)	Maximum Error 2	Year	Year	Year	x 2 =	Year	Year	Year

Error Points	John (1)	Brown (1)	42 (1)	Market Street (1)	Chicago (1)

Maximum Weight Error Score = 28	Year:	Total Weighted Error Score:
	Year:	Total Weighted Error Score:
	Year:	Total Weighted Error Score:

Cognitive Deficits

The following scale is used to assess the applicant's cognitive deficits (questions 7-11). Please write in the scores for cognitive deficits. Descriptions of the cognitive deficits must be included.

0	No Problem	Applicant has intact abilities.
1	Minimal Problem	Problems do not interfere with independence and activities of daily living, but may compromise functioning in complex activities — requires rare cueing..
2	Mild Problem	Problems do not interfere with independence in routine and familiar situations, but may limit independence or impair functions in complex or unfamiliar activities. Requires cueing to either start or complete task.
3	Mild- to- Moderate Problem	Problems limit independence and interfere with functioning in routine and familiar situations. May require supervision for some activities, but be able to stay alone for periods of time. Requires cuing and/or occasional assistance to start and complete task.
4	Moderate Problem	Problems limit independence and interfere with functioning in routine and familiar situations, needing moderate levels of assistance and supervision. Requires occasional supervision and/or assistance to complete task.
5	Moderate -to- Severe Problem	Problems limit independence and interfere with functioning in routine and familiar situations, needing maximum assistance and constant supervision. Requires maximum supervision and/or assistance to complete task.
6	Severe Problem	Applicant requires constant visual supervision during day and nighttime awake staff. Completely dependent.

7. **Attention and Concentration**	Year:	Year:	Year:
	Score:	Score:	Score:

Examples include: difficulty sustaining attention; easily distracted; unable to filter out irrelevant information, frequently gets lost in group conversation; reduced arousal, sleepiness.

Describe: _____

8. **Learning and Memory**	Year:	Year:	Year:
	Score:	Score:	Score:

Examples include: difficulty in organizing or processing information; specific memory deficits remembering visual information rather than verbal auditory or vice versa; difficulty learning due to short-term memory deficits; problems remembering basic routines, (i.e., self-care, daily routine, Activities of Daily Living [ADLs]).

Describe: _____

_____

_____

Cognitive Deficits

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6	Severe Problem	Applicant requires constant visual supervision during day and nighttime awake staff. Completely dependent.

9. **Judgment and Perception**	Year:	Year:	Year:
	Score:	Score:	Score:

Examples include: misinterpretation of the actions or intentions of others; easily confused by

multiple pieces of information presented at one time; socially inappropriate in verbal communication; unrealistic appraisal of his/her strengths and weaknesses.

Describe: _____

_____

_____

10. **Initiation and Planning**	Year:		Year:		Year:	
	Score:		Score:		Score:	

Examples include: interprets information literally, concrete thinking; difficulty starting or stopping an action, impulsiveness; slow initiation time; confusion of where to start solving a problem, unrealistic problem-solving strategies; difficulty in sequencing information; difficulty in knowing when, where, and how to ask for help; trouble learning from mistakes, as well as successes.

Describe: _____

_____

_____

Cognitive Deficits

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6	Severe Problem	Applicant requires constant visual supervision during day and nighttime awake staff. Completely dependent.

11. Communication	Year:	Year:	Year:
	Score:	Score:	Score:

Examples include: tangential communication (structure of sentences are complete, but irrelevant to the situation or topic); talkativeness; use of peculiar words or phrases; confabulation (making up responses); perseveration (repetition of the same response when it is no longer appropriate); disinhibited choice of words.

Describe: _____

_____

_____

Total Scores		
Year:	Year:	Year:
Total Score:	**Total Score:**	**Total Score:**

PART III HEALTH ASSESSMENT

A. Health Problems

1. (Ask:) Do you have any health problems other than brain injury that affects your daily living? For instance, has a doctor told you that you have any of the following health problems or symptoms of health problems? (Read health conditions to client.)

HEALTH CONDITIONS COMMENTS			
	Year	Year	Year
Allergies (type) (drug/skin/etc.):			
Anemia (type):			
Arthritis (type):			
Asthma (type):			
Bladder/kidney problems urinary track infection (UTI), etc.:			
Falls that occurred during the past year:			
Hearing problems:			
Paralysis (site):			
Seizure disorders (epilepsy, etc.):			
Sleep problems:			
Stroke (Cerebral Vascular Accident, (CVA)etc):			
Thyroid Problems (Graves, myxedema, etc.):			
Ulcers (type, site):			
Vision problems (cataracts, glaucoma, etc.):			
Other (specify):			

MEDICATION USE

2. (Ask:) How do you remember to take your medications? (Do not read list. Check answer.)

	Year	Year	Year
Care giver gives them			
Egg carton, envelopes			
Plastic pill minder			
Calender			
Follows directions on label			
Other (specify):			

3. Interviewer answers: Are you concerned that the client is:(Each affirmative answer is worth 2 points.)	Year	Year	Year	Comments/Care Plan Implications:
Not taking medications on time?				
Not taking proper number of medications?				
Taking medications prescribed for other?				
Not getting prescription properly filled?				
Not getting medication needs reevaluated?				
Not getting medications due to cost?				
Affected by medication side effects?				
Taking prescriptions from too many physicians?				
Using outdated medications?				
Refusing to take medications?				
Having other medication problems? (specify)				

4. (Ask:) Do you take 3 or more prescribed or over the counter medications daily? (Score 2 if answer is yes.)	Year	Year	Year
Medication Score:			

MEDICAL UTILIZATION

5. (Ask:) In the past six months have you seen a doctor (or physician's assistant, nurse practitioner? Been admitted to a hospital? Gone to any emergency room?

Year____	Year _____	Year _____
☐ Yes (Complete below)	☐ Yes (Complete below)	☐ Yes (Complete below)
☐ No	☐ No	☐ No
☐ Don't know	☐ Don't know	☐ Don't know

Name of Physician:
Hospital/emergency room admission date:
Hospital/emergency room discharge date:
Reason for visit/admission:_____

6. (Ask:) Have you ever been a resident of a nursing home or similar place?

Year____	Year _____	Year _____

☐ Yes (Complete below)	☐ Yes (Complete below)	☐ Yes (Complete below)
☐ No	☐ No	☐ No
☐ Don't know	☐ Don't know	☐ Don't know

Admission date: _____ Discharge date:_____

Name of facility:_____ Reason for admission: _____

7. (Ask:) Do you have or need any of the following special equipment, assistive devices, or aids?

Year_____				Year_____				Year_____		
Prosthesis (type)	Ha & Use	Has, bu Doesn' Use	Needs, but Does Not Have	Has & Uses	Has, bu Doesn' Use	Needs, but Does Not Have	Has & Uses	Has, but Doesn't Use	Needs, but Does Not Have
Cane	☐	☐	☐	☐	☐	☐	☐	☐	☐
Walker	☐	☐	☐	☐	☐	☐	☐	☐	☐
Wheelchair	☐	☐	☐	☐	☐	☐	☐	☐	☐
Brace (leg/back)	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hearing aid	☐	☐	☐	☐	☐	☐	☐	☐	☐
Glasses	☐	☐	☐	☐	☐	☐	☐	☐	☐
Contact lenses	☐	☐	☐	☐	☐	☐	☐	☐	☐
Dentures	☐	☐	☐	☐	☐	☐	☐	☐	☐
Emergency Alert Response (EAR)	☐	☐	☐	☐	☐	☐	☐	☐	☐
Bedside commode	☐	☐	☐	☐	☐	☐	☐	☐	☐
Bathing equipment	☐	☐	☐	☐	☐	☐	☐	☐	☐
Transfer equipment	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hospital bed	☐	☐	☐	☐	☐	☐	☐	☐	☐
ADL adaptive equipment	☐	☐	☐	☐	☐	☐	☐	☐	☐
Adaptive eating equipment	☐	☐	☐	☐	☐	☐	☐	☐	☐
Disposable medical supplies	☐	☐	☐	☐	☐	☐	☐	☐	☐
Communication devices	☐	☐	☐	☐	☐	☐	☐	☐	☐
Physical therapy	☐	☐	☐	☐	☐	☐	☐	☐	☐
Occupational therapy	☐	☐	☐	☐	☐	☐	☐	☐	☐
Speech therapy	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other (Specify)	☐	☐	☐	☐	☐	☐	☐	☐	☐

ALCOHOL/TOBACCO USE: SUBSTANCE ABUSE			
8. (Ask:) (Score 1 if answer is yes.)			
Do you drink any alcoholic beverages, including beer and wine?	Year	Year	Year
Does anyone else think you use alcohol?			
On average, counting beer, wine and other alcoholic beverages, how much do you drink? (amount and frequency)			
9. (Ask:) (Score 1 if answer is yes.)			
Do you smoke or use tobacco?	Year	Year	Year

Does anyone else think you use tobacco?				
10. (Ask:) (Score 1 if answer is yes)				
Do you use illegal substances (drugs)?		Year	Year	Year
Does anyone else think you use illegal substances?				
11. How concerned are you, as the interviewer, about the client's alcohol use, substance abuse, and/or careless smoking?				
Year:	Not Concerned (0)	Slightly Concerned (1)	Mildly Concerned (2)	Moderately Concerned (3)	Extremely Concerned (4)
Total Alcohol/Tobacco Use: Substance Abuse Score:					

NUTRITION

12. (Ask:) How is your appetite?	Year			Year			Year		
	Good	Fair	Poor	Good	Fair	Poor	Good	Fair	Poor

(Ask:) Have you gained or lost a significant amount of weight in the last six months? (Score 2 if answer is yes.)

Year:	No (0)	Yes	Gain:	Loss:
Year:	No (0)	Yes	Gain:	Loss:
Year:	No (0)	Yes	Gain:	Loss:

Describe gain or loss: 10% change is significant:

_____

_____

_____

13. (Ask:) Do you have any problems that make it difficult to eat? Score 1 if answer is yes

For example, do you have:	Year:	Year:	Year:	Comments/Care Plan
Tooth or mouth problems				
Swallowing problems				
Nausea				
Taste problems				
Can't eat certain foods				
Any food allergies				
Any other problems with eating				
(Describe):				

14. (Ask:) Are you on any special diets for medical reasons?

What type of special diet(s) are you on? (Check any diets. Mark score in box by diet score below)

	Year:	Year:	Year:	Comments/Care Plan Implications:

Low sodium (salt)				
Low fat				
Low sugar/cholesterol				
Calorie supplement				
Other special diet				
(Describe):				
(1 special diet 1 point, 2 or more diets 2 points. Maximum score 2) **Diet score**				

15. (Ask:) Is there anything else we need to know that makes it difficult for you to eat properly?		Yes	No
(Describe):			

Total Nutrition Score (weight, eating problems, special diet):

16. (Ask:) Overall, do you consider your health as excellent, good, fair or poor (Score excellent (0), good (1), fair(2),poor(3))			
	Year:	Year:	Year:
Total Score PART III Health Assessment:	Year:	Year:	Year:
(Ask:) Do you have any new health problems? (Describe any care plan implications.)			
Comments (Summary):_____			

PART IV FUNCTIONAL ASSESSMENT (ADLS)

A. Functional Assessment (ADLs)

Address all questions to the client, if possible. The purpose of these questions is to determine actual *ability* to do various activities. Sometimes care givers help the client with an item regardless of the person's ability. Ask enough questions to make sure the client is telling you what he/she can or cannot do.

Response Definitions:

0 Point:: No help. Client needs no help to perform any part of the activity.
2 Points: Some help. Client needs physical help, reminders, or supervision during part of the activity.
3 Points: Can't do it at all. Client cannot complete activity without total physical assistance.

ADL Total Score: Add scores in yearly column.

Activities of Daily Living				
	Year	Year	Year	Comments:
1. **Dressing** (Includes getting out of clothes and putting them on, and fastening them, and putting on shoes.)				
2. **Grooming** (Includes combing hair, washing face, shaving, and brushing teeth.)				
3. **Bathing** (Includes running the water, taking the bath or shower, and washing all parts of the body, including hair.)				
4. **Eating** (Includes eating, drinking from a cup, and cutting foods.)				
5. **Transferring** (Includes getting in and out of a bed or chair.)				
6. **Walking/Mobility** (Includes walking around with a cane or walker or using a wheelchair. Independence in walking refers to the ability to walk short distances at home. Independence in walking does not include climbing stairs.)				
7. **Climb Stairs** (Ability to use stairs safely.)				
8. **Toileting** (How well can you manage using the toilet? Using the toilet independently includes, adjusting clothing, getting to and on the toilet, and cleaning one's self. If accidents occur and person manages it alone, count it as independent. If reminders are needed to use the toilet, this counts as "some help/ supervision.")				
9. **Bladder/Bowel Control** (How well can you control your bladder or bowel?) Seldom has accident - less than yearly - score 0 Occasionally have accidents –less than 6 months – score 2 Have accidents monthly – score 3 Have accidents weekly – score 4 - enter score				
10a. Does client wear incontinent briefs? If yes, go to 10b. (No score)	Y N	Y N	Y N	
10b. Do you need help in changing them (incontinent briefs)?	Y N	Y N	Y N	
Total ADL Score:				

B. Instrumental Activities of Daily Living (IADLs)

Address all questions to the client, if possible. The purpose of these questions is to determine actual *ability* to do various activities. Sometimes care givers help the client with

an item regardless of the person's ability. Ask enough questions to make sure the client is telling you what he/she can or cannot do.

Response Definitions:

0 Point: No help. Client needs no help to perform any part of the activity.
2 Points: Some help. Client needs physical help, reminders, or supervision during part of the activity.
3 Points: Can't do it at all. Client cannot complete activity without total physical assistance.

Instrumental Activities of Daily Living (IADL) Total Score: Add scores in yearly column.

IADLs				
	Year	Year	Year	Comments:
1. **Answer the telephone effectively** (includes the use of an amplifier or special equipment)				
2. **Making a telephone call** (ability to call on the telephone)				
3. **Shopping** (includes shopping for food and other things you need, but does not include transportation)				
4. **Transportation ability** (includes using local transportation or driving to places beyond walking distance)				
5. **Prepare meals** (includes preparing meals for yourself, including sandwiches, cooked meals, and TV dinners)				
6. **Laundry** (includes doing laundry, including putting clothes in the washer or dryer, starting and stopping the machine, and drying the clothes)				
7. **Light housekeeping** (includes dusting, vacuuming, sweeping, etc., but does not include laundry)				
8. **Heavy chores** (includes yard work, windows, moving furniture, but does not include laundry)				
9. **Taking medication** (ability to take your own medication)				
10. **Managing money** (includes managing your own money, such as paying your bills, or balancing your checkbook)				
TOTAL IADL SCORE:				

Comments/Summary

PART V SOCIAL RESOURCES

A. Social Resources

	Year	Year	Year
1. (Ask:) Do you live alone? (If yes, score 2 points and complete information below. If no, score 0 points.)			
2. (Ask:) Do you have someone who could stay with you for awhile if you needed it. Or, if you were sick? (If yes, score 0 points. If no, score 2 points.)			
Total Score:			

Name: _____
Relation: _____
Address: _____
City: _____ Phone: _____
State: _____ Zip: _____

3. (Ask:) If you could not longer continue to live in your present location, do you have any thoughts about where you would like to go?			
	Year:	Year:	Year:
Home			
Smaller home (apartment, mobile home)			
Relative's home (specify):			
Board and care home			
Nursing home			
Other (specify):			
Don't know			

4 (Ask:) Do you have someone you can talk to when you have a problem? _____ (If yes score 0 points, If no score 2 points) (If yes, complete below.) Name: _____ Relation to Client: _____	Year	Year	Year

5. Do you have a pet ?	☐	Yes (Specify)	☐	No

6. (Ask:) About how many times do you talk to friends, relatives or	Year	Year	Year

others on the telephone in a <u>week</u>, (either they call you or you call them)?			
Once a day or more (Score 0 points)			
2 - 6 times a week (Score 1 point)			
Once a week (Score 1 point)			
Not at all (Score 2 points)			
No phone (Score 2 points)			
Don't know (Score 2 points)			

7. (Ask:) How many times during a week do you spend time with someone who does not live with you? That is, you go to see them or they come to visit you, or you do things together?	Year	Year	Year
Once a day or more (Score 0 points)			
2 - 6 times a week (Score 1 point)			
Once a week (Score 1 point)			
Not at all (Score 2 points)			
Don't know (Score 2 points)			

8. (Ask:) What activities do you enjoy?

9. (Ask:) If you want to attend religious services or other community groups, are you able to attend as often as you like?

Year ___		Yes		No	
Year ___		Yes		No	
Year ___		Yes		No	

SOCIAL RESOURCES TOTAL SCORE:

Comments/Care Plan Implications:

PART VI MENTAL HEALTH

A. Mental Health

1. (Ask:) Are you currently or have you previously received mental health services or counseling? (If yes, complete #2 below.) (Questions #3 thru #11 to be completed on all persons regardless of history of mental health services)

2. Sources of information regarding Mental Health Services.		Client:
Other: (specify below)		
Year:	Name of agency/therapist:	Comments:
Year:	Name of agency/therapist:	Comments:
Year:	Name of agency/therapist:	Comments:

3. (Interviewer or support person- family member, friend, should respond:) Does the client . . . (Check box if answer is yes.)	Year:	Year:	Year:
Appear to be depressed, lonely, or dangerously isolated?	☐	☐	☐
Wander away from home, etc. for no apparent reason?	☐	☐	☐
Need supervision? (If yes, specify how much; e.g., constant, at night only, etc.)	☐	☐	☐
Pose a danger to self or others?	☐	☐	☐
Demonstrate significant memory problems?	☐	☐	☐
Other (Specify)	☐	☐	☐

4. Does the client require. . . (Check box if answer is yes.)	Year	Year	Year
Mental Health Assessment	☐	☐	☐
Mental Health Referral	☐	☐	☐
Neither	☐	☐	☐

BEHAVIOR/EMOTIONAL DEFICITS
The following scale is used to assess the frequency of the applicant's behavioral problems. Please write in the scores for behaviors 5 to 11. Descriptions of the behaviors must be included.

0	Absent	
1	Rarely	Less than once a month
2	Occasionally	At least once a month, but not weekly
3	Frequently	More than once a week, but not daily
4	Daily	On a daily basis
5	Hourly	Continuously throughout the day

5. **Self Injurious Behavior**

Year:		Year:		Year:	
Score:		Score:		Score:	

Engages in deliberate behavior that causes injury or has potential for causing injury to his/her own body. Examples include: self-hitting, self-biting, head-banging, self-burning, self-poking or stabbing, ingesting foreign substances, pulling out hair, purposeful tipping of wheelchair.

Describe:

_____

_____

_____

6. **Hurtful to Others**

Year:		Year:		Year:	
Score:		Score:		Score:	

Engages in behavior that causes physical pain to other people or animals. Examples include: hitting, pinching, kicking, and inappropriate sexual physical contact.

Describe:

_____

_____

_____

7. **Destruction of Property**

Year:	Year:	Year:
Score:	Score:	Score:

Damages, destroys, or breaks things. Examples include: breaking windows, lamps, or furniture, tearing clothes, setting fires, using tools or objects to damage property.

Describe:

_____

_____

BEHAVIOR/EMOTIONAL DEFICITS		
The following scale is used to assess the frequency of the applicant's behavioral problems. Please write in the scores for behaviors 5 to 11. Descriptions of the behaviors must be included.		
0	Absent	
1	Rarely	Less than once a month
2	Occasionally	At least once a month, but not weekly
3	Frequently	More than once a week, but not daily
4	Daily	On a daily basis
5	Hourly	Continuously throughout the day

8. **Socially Offensive Behavior**

Year:	Year:	Year:
Score:	Score:	Score:

Behavior that is offensive to others or that interferes with the activity of others. Examples include: spitting, urinating in inappropriate places, stealing, screaming verbal harassment, bullying, and masturbating in public.

Describe:_____
_____
_____

9. **Wandering**

Year:	Year:	Year:
Score:	Score:	Score:

Departs from home unexpectedly. Examples include: leaving the living area for extended periods of time without informing appropriate persons, running away, wandering away while in community.

Describe:_____
_____
_____

10. **Withdrawal Behavior**

Year:	Year:	Year:
Score:	Score:	Score:

Excessively avoids others or situations calling for personal interaction to a point where this behavior significantly interferes with participation in normal daily activities. Examples include: refusing to talk to others, remaining in his/her room for inordinate periods of time, repeatedly declining opportunities to recreate with others, extreme passivity, which leads to

victimization.

Describe:_____

_____

_____

BEHAVIOR/EMOTIONAL DEFICITS		
The following scale is used to assess the frequency of the applicant's behavioral problems. Please write in the scores for behaviors 5 to 11. Descriptions of the behaviors must be included.		
0	Absent	
1	Rarely	Less than once a month
2	Occasionally	At least once a month, but not weekly
3	Frequently	More than once a week, but not daily
4	Daily	On a daily basis
5	Hourly	Continuously throughout the day

11. **Susceptibility to Victimization**

Year:	Year:	Year:
Score:	Score:	Score:

Lacks sufficient level of judgment or self-protection ability and/or possesses skill deficits which place the person at an increased risk of neglect, physical harm, emotional distress, sexual or financial exploitation, or monetary loss. Examples include: inappropriately familiar with strangers, unaware of monetary values, inability to recognize risky situations, or insufficient ability to seek assistance.

Describe:

_____

_____

_____

Total Score:

PART VII COMPREHENSIVE ASSESSMENT SCORING MATRIX

Comprehensive Assessment/Reassessment Form Scoring Matrix — Year				
		Score		
		Year:	Year:	Year:
Cognitive Functioning (MSQ)	PART II #1-6			
Cognitive Deficits	PART II #7-11			
Medication Issues	PART III #2-4			
Substance Abuse	PART III #8-11			
Nutrition	PART III #12-15			
Health Evaluation	PART III #16-17			
ADLs	PART IV A # 1-8,9			
IADLs	PART IV B #1-10			
Social Resources	PART V #1,2,4,6,7,			
Mental Health/Behavioral	PART VI #5-11			
TOTAL SCORE:				

Signatures: **Date: Mo/Day/Year**

Support Co-ordinator: _____
_____

Client: _____ _____

Other Participant:_____ _____

Signatures: **Date: Mo/Day/Year**

Support Co-ordinator: _____
_____

Client: _____ _____

Other Participant:_____ _____

Signatures: **Date: Mo/Day/Year**

Support Co-ordinator: _____
_____

Client: _____ _____

Other Participant:_____ _____